AGENCY APPLICATION FOR ONE-TIME DDP TRAINING GRANT – FY2015 –

AGENCY NAME:

AGENCY ADDRESS:

AGENCY PHONE:

AGENCY CONTACT:

NAME: TITLE:

PHONE: E-MAIL:

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PRESENTER NAME AND BRIEF DESCRIPTION OF QUALIFICATIONS:

ANTICIPATED DATE OF TRAINING:

TOPIC OF PROPOSED TRAINING: (Specifically describe the information to be presented by the training)

TRAINING RATIONALE: (specifically describe how the training addresses the following criteria)

RELATION OF TRAINING TO EVIDENCE-BASED BEST PRACTICES FOR PROVISION OF SERVICES TO INDIVIDUALS CURRENTLY SERVED BY THE AGENCY:

RELATION OF TRAINING TO SERVICES CURRENTLY PROVIDED UNDER MONTANA DDP MEDICAID WAIVERS

SPECIFIC MEDICAID WAIVER SERVICES CURRENTLY PROVIDED ENHANCED BY THIS TRAINING WITHIN THE AGENCY:

ANTICIPATED SERVICE IMPROVEMENT TO INDIVIDUALS CURRENTLY SERVED WITHIN THE AGENCY:

ANTICIPATED LONG-TERM BENEFIT TO AGENCY STAFF PROVIDED THROUGH THIS TRAINING: